Part III Actuarial Memorandum

Highmark BCBSD, Inc.

d/b/a Highmark Blue Cross Blue Shield Delaware

Individual Rate Filing

Effective January 1, 2019

TABLE OF CONTENTS

I. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Highmark Blue Cross Blue Shield Delaware's (Highmark DE) individual block of business rate filing, for products with an effective date of January 1, 2019. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the State of Delaware Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Highmark DE's rate filing. However, we recognize that this certification may become a public document. Highmark DE makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum that would result in the creation of any duty or liability under any theory of law by Highmark DE.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

I.1 Company Identifying Information:

- Company Legal Name: Highmark Blue Cross Blue Shield Delaware
- State: The State of Delaware has regulatory authority over these policies.
- HIOS Issuer ID: 76168
- Market: Individual
- Effective Date: January 1, 2019

I.2 Company Contact Information:

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

II. Proposed Rate Increase(s)

For all rate increases by plan see the 'Cum'tive Rate Change % (over 12 mos prior)' found in Worksheet 2 Row 27 of the URRT. The rate increase varies by plan due to an update in several of our pricing factors and changes in benefits required to meet Actuarial Value and other cost sharing restrictions under the Affordable Care Act.

The primary drivers of the rate increase are increasing medical and pharmacy services in the Individual market.

The rate development in this filing is based on certain assumptions we have had to make at this point in time. We have assumed that the ACA health insurance coverage mandate is eliminated, and that cost sharing reduction (CSR) payments will remain ceased for 2019. We have included an assumed [redacted] load for expected adverse selection due to the Short Term Limited Durational Insurance market expansion based on a recently proposed HHS rule modifying federal requirements for this market. We have also included an assumed [redacted] load for Delaware Senate Bill 227 which is expected to increase provider reimbursement related to Primary Care and Chronic Pain Management. Additional assumptions include that advance payment of premium credits (APTCs) will continue until the end of 2019, there will be no significant changes in legislation, regulations or otherwise (i.e. rules, regulatory guidance, etc.) impacting the ACA market, and there will be an additional QHP issuer participating on the Marketplace throughout 2019. In addition, there are other uncertainties that may directly or indirectly affect an already unstable insurance market and ultimately, rates. If any of these assumptions are ultimately incorrect or additional developments occur that similarly have a detrimental impact to the market, modifications to the rate development may be necessary. As a result, Highmark DE reserves the right to submit a revised filing.

III. Experience Period Premium and Claims

III.1 Paid through Date:

Experience Period claims were based on incurred calendar year 2017, paid through February 2018. This includes 2017 experience in Affordable Care Act compliant plans. Highmark DE did not offer any transitional plans in 2017.

III.2 Premiums (net of MLR Rebate) in Experience Period:

The premiums shown for the experience period were based on calendar year 2017 actual revenues.

Based on preliminary information for calendar year 2017, no MLR rebates are anticipated to be refunded to enrollees. Therefore, we did not include an adjustment for MLR rebates in the 2017 premium amounts.

III.3 Allowed and Paid Claims Incurred During the Experience Period:

- Historical Experience: We chose Highmark DE's current experience for the individual block of business for the period January 1, 2017 through December 31, 2017, with claims paid through February, 2018 as the basis for the 2019 projected individual market pricing.

- Claims Incurred During the 12-month Experience Period: Worksheet 1, Section I shows our best estimate of the amount of claims that were incurred during the 12-month experience period for Highmark DE's individual book-of-business. This section includes:

  - The amount of claims which were processed through Company's claims system,

  - Claims processed outside of the Company's claims system, and

  - Our best estimate of claims incurred but not paid as of the paid through date stated above.

- Method for Determining Allowed Claims: For non-capitated claims, the allowed charges are summarized from Highmark DE's detailed claim-level historical data. This experience includes 2017 claims for Affordable Care Act compliant business. For capitated and other off-system claims, historical capitations and experience were tabulated and added to the claims.

- Paid Claims: We also summarized the paid claims from detailed member records. The paid-to-allowed ratio for the experience period reflects the 2017 plan designs chosen by each member.

- Incurred but Not Paid (IBNR) Claims Estimate: Highmark DE is using a completion factor of [redacted] to include IBNR claims in allowed charges. The IBNR completion factor was developed using our corporate reserving system for Highmark DE's individual business. We applied it equally to both paid and allowed total claims (as a change to utilization) to complete the experience.

IV. Benefit Categories

Historical cost and utilization data was summarized at the defined benefit categories included in Worksheet 1, Section II of the URRT. This data was used to allocate total claims into its components on the URRT.

The data provided in this section closely adheres to the preferred definitions of the Benefit Categories included in the URRT instructions, including the "Other Medical" category. The "Other Medical" category units reflect visits for PDN/home health, trips for ambulance and

procedures for DME/prosthetics. Prescription drugs utilization were converted to a "per 30-day" script count.

V. Projection Factors

V.1 Changes in the Morbidity of the Population Insured

We applied an adjustment of approximately [redacted] to reflect the anticipated changes in the average morbidity of the covered population (beyond allowable rating factors). This morbidity adjustment reflects multiple changes, including blending of the ACA pool and new members from multiple sources including uninsured and the employer markets.

Impact of Health Insurance Coverage Mandate

The morbidity factor was increased by [redacted] to reflect the market uncertainty from the elimination of the health insurance coverage mandate. This deterioration is reflected in the filing by multiplying the original morbidity factor of [redacted] by [redacted] to arrive at a final morbidity factor of approximately [redacted].

V.2 Changes in Benefits

All known benefit changes pertained to changes in cost sharing which are captured in the paid to allowed ratio discussed in Section VIII.

V.3 Changes in Demographics

We project that the average rating factor (age, tobacco load and area combined) will increase by about [redacted] due to the change in the population. This is primarily due to the expectation that the new members from the group and/or uninsured populations to be slightly older than the population in the underlying experience. This increases the projected allowed claims (utilization) by the same amount.

V.4 Trend Factors (cost/utilization)

This development of the CY2019 rates reflects an annual trend rate of [redacted] ([redacted] cost, [redacted] utilization). These trends reflect Highmark DE's expectations regarding increases in in-network contractual reimbursement and out-of-network costs. These estimates measure and normalize for benefit leverage, population aging, and historical changes for fee schedules, as well as company-wide utilization management programs, and external trend drivers.

The trend represents a blended average for all types of service and is applied to the aggregate experience for pricing. These trends represent assumed community-wide expectations. Claim variations due to the specific projected enrolled population in this single risk pool are reflected in the morbidity adjustment.

Please note that while the underlying utilization trend is expected to be [redacted] Highmark has included the anticipated change in utilization due to cost sharing requirements in the

utilization trend column as instructed. The utilization adjustment is [redacted] per year. This brings the final utilization trend to [redacted] as found in the URRT.

VI. Credibility Manual Rate Development

VI. 1 Source and Appropriateness of Experience Data Used

Highmark DE's individual experience is fully credible. No manual rate is developed or used in this projection. The Credibility Manual section of the URRT has been populated with zeroes to allow for finalization of the URRT Workbook.

VII. Credibility of Experience

The experience is from Highmark DE's individual book of business in 2017. It is large enough to be fully credible. Our results are based [redacted] on the experience rate, as adjusted.

VIII. Paid to Allowed Ratio

The paid to allowed ratio of [redacted] is a weighted average of the 2019 plan level paid to allowed ratios. Plan level paid to allowed factors were developed using an internal model based on DE individual claims experience. The paid to allowed factors for silver plans not offered exclusively off-exchange were loaded an additional [redacted] to cover the anticipated cost of the Federal Government's decision not to fund Cost Sharing Reduction subsidies.

IX. Risk Adjustment and Reinsurance

IX.1 Projected Risk Adjustments PMPM:

[redacted]

X. Non-Benefit Expenses and Profit & Risk

X.1 Administrative Expense Load:

The proposed rates reflect internal administrative costs including commissions and quality improvement administrative expenses. This cost was developed based on standard expense allocation methods.

X.2 Profit (or Contribution to Surplus) & Risk Margin:

The proposed rates reflect a [redacted] risk/contribution to surplus margin for all products and plans.

X.3 Taxes and Fees:

The following fees were added:

- [redacted] Per Member Per Month for the Patient Centered Outcomes Research Institute Fee.
- [redacted] for the Health Insurance Provider Fee
- [redacted] Exchange Fee x [redacted] assumed on exchange percentage (= [redacted] included in the single risk pool base rate)

XI. Projected Loss Ratio

The anticipated medical loss ratio is about [redacted] relative to total premium less taxes and fees. This loss ratio is calculated consistently with the federally prescribed MLR methodology.

XII. Single Risk Pool

As described above the base experience used includes all Highmark DE individual members in accordance with the Single Risk Pool regulations. The projected membership and their corresponding premiums and claims only include those members who will be enrolled in a fully ACA-compliant plan in 2019.

XIII. Index Rate

Please see Exhibit 1 for the numerical development of the projected index rate. The index rates as shown on Worksheet 1 of the URRT are simply the average allowed claims for the Essential Health Benefits for the experience and projected populations, respectively, for Highmark DE. For the experience period, only non-grandfathered plans are included. The projection period Index Rate is not adjusted for reinsurance or risk adjustment programs or any other fee.

XIV. Market Adjusted Index Rate

Please see Exhibit I for a numerical demonstration of the Market Adjusted Index Rate development. The Market Adjusted Index Rate is the Index Rate further adjusted for risk adjustment, reinsurance, and the exchange fee. The Risk Adjustment factor is developed by taking one minus the expected risk transfer (net of the fee) and dividing by the projected incurred claims before reinsurance and risk adjustment. The Federal Reinsurance Program factor is set to one to recognize the program's termination. The Exchange User Fee factor is developed by adding the expected average exchange fee PMPM and the projected incurred claims after risk adjuster and reinsurance, then dividing by the projected incurred claims after risk adjuster and reinsurance. These adjustments were developed as factors in accordance with the Part III instructions.

XV. Plan Adjusted Index Rates

A Plan Adjusted Index Rate is developed by taking the Market Adjusted Index Rate and adding a plan's actuarial value, relative benefit richness, any non EHB benefits, and retention. Please see Exhibit II for the development of the Plan Adjusted Index Rate for each plan. All plans are offering the same non-EHB benefits, and the administrative expenses and profit and risk load factors do not vary by plan.

XVI. Calibration

XVI.1 Age Curve Calibration:

The projected weighted average age factor for billable members is [redacted]. This factor is calculated by dividing the all members age factor of [redacted] by the ratio of billable members to total members [redacted]. Each Plan Adjusted Index Rate represents the rate for an average member with an age factor of [redacted]. Please note that no member will pay these rates because the age factor of [redacted] is not found on the HHS Age Curve. It only represents the average age factor of the projected population. The nearest age to that factor is for age [redacted], which has a factor of [redacted]. Please see Exhibit I for the development of the calibration factor.

XVI.2 Geographic Factor Calibration:

The state of Delaware has only one geographic region and a factor of [redacted]. No calibration is necessary.

XVI.3 Tobacco Factor Calibration:

The projected weighted average tobacco factor is [redacted]. Each Plan Adjusted Index Rate represents the rate for an average member with a tobacco factor of [redacted]. Please see Exhibit I for the development of the calibration factor.

XVII. Consumer Adjusted Premium Rate Development

The plan adjusted index rate represents the rate for an average age and average geographic member with a mix of tobacco users and non-tobacco users. Multiplying by the Combined Calibration Factor found in Exhibit I results in the value for a [redacted] year old non-tobacco user in a [redacted] geographical area. The standard HHS Age Curve along with the filed tobacco factors and geography factors can be used to calculate any rate found in the QHP rate template.

XVIII. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based entirely on the Federal AV Calculator. Some plans did require an adjustment to the inputs entered into the AV calculator. Screen shots and certifications for these plans were submitted as part of Highmark DE's QHP application.

XIX. AV Pricing Values

Please see Exhibit II for the portion of each AV pricing value that is attributable to each of the allowable modifiers. The utilization due to differences in cost sharing is based on the factors adopted by the risk adjustment methodology. No differences due to health status are in these adjustments.

Impact of Non-Payment of Cost Sharing Reduction Subsidies

We have applied an additional adjustment to our AV pricing values for those Silver plans not offered exclusively off-exchange. This adjustment factor was [redacted] and represents the non-payment of Cost Sharing Reduction subsidies. This adjustment factor was reflected in Column (i) of Exhibit II for the impacted plans.

XX. Membership Projections

Membership projections is from the Highmark DE's forecast for 2019. These projections reflect expected changes in market share due to an expected increase in market competition.

Highmark DE expects membership in 2019 to follow a similar distribution as the Individual ACA experience period.

For the Silver level plans, the projected membership by cost sharing subsidy levels is based on the observed distribution of ACA members that were eligible under the federal poverty levels and reflects the increased cost on silver rates and the availability of premium subsidies. The projected enrollment by plan and subsidy level is as follows:

CSR Silver Plan Membership Distribution			
FPL	Subsidy Level	% of Silver Membership	% of Total Membership
<150%	94%	[redacted]	[redacted]
150%-200%	87%	[redacted]	[redacted]
200%-250%	73%	[redacted]	[redacted]
>250%	70%	[redacted]	[redacted]
Total		[redacted]	[redacted]

XXI. Terminated Plans and Products

All terminated plans are listed in Exhibit III.

XXII. Plan Type

The Plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template describe Highmark DE's plans adequately.

XXIII. Warning Alerts

The URRT validated with no warnings.

XXIV. Actuarial Certification

I, [redacted], am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. This filing is prepared to accompany Highmark DE's rate filing for the individual combined market on and off the Delaware Exchange.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The allowable modifiers used to generate plan-level rates were:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the essential health benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

I certify that the per cent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I certify that the benefits included in Highmark DE's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Delaware's benchmark plans. I certify that any benefit substitutions are:

- Actuarially equivalent to the benefits being replaced,
- Are made within only the same essential health benefit category,
- Are based on a standardized plan population,
- Are determined regardless of cost-sharing,
- Are not prescription drug benefits, and
- Are based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator.

I certify that the geographic rating reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

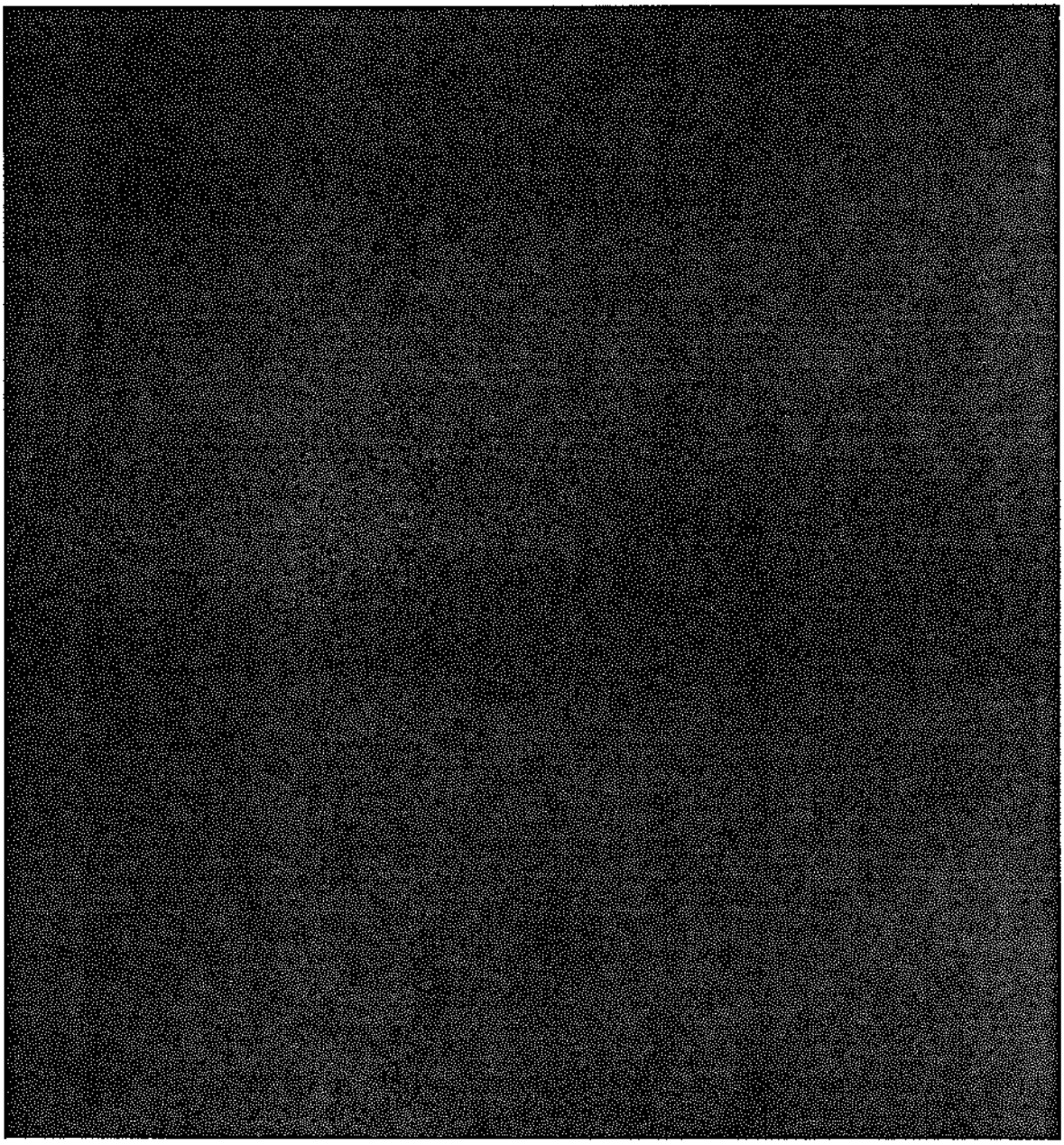
The Part I Unified Rate Review Template does not demonstrate the process used by Highmark DE to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index

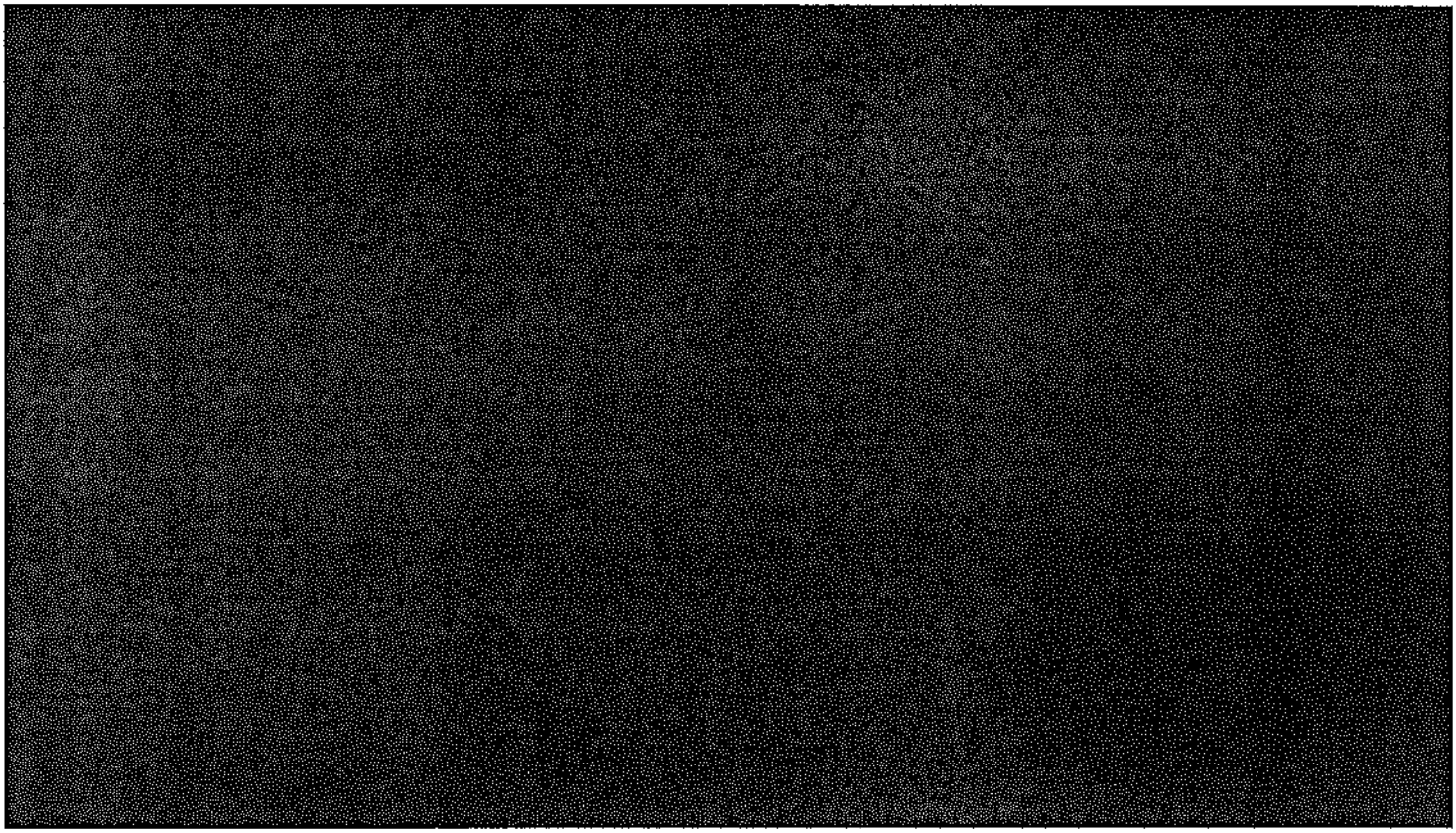
rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

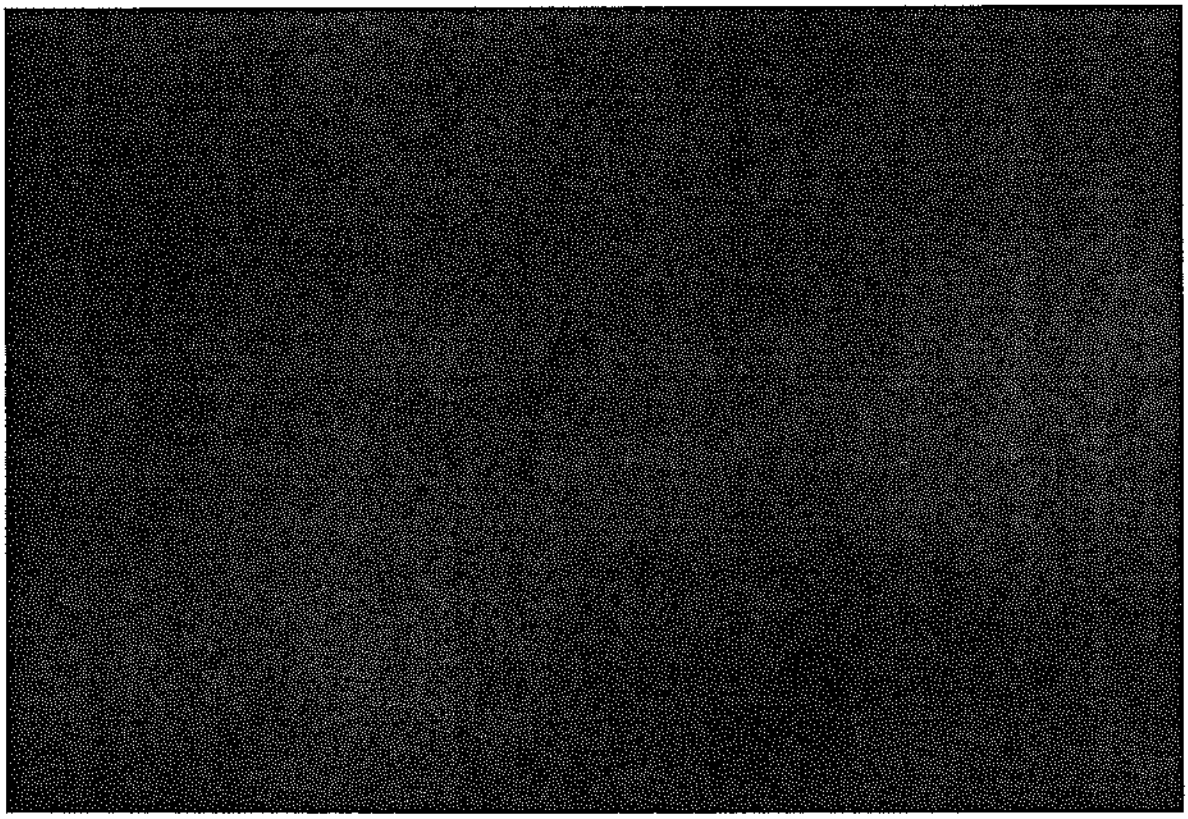
Signed: [redacted]

Title: [redacted]

Date: June 21, 2018







Milliman

1550 Liberty Ridge Drive, Suite 200
Wayne, PA 19087-5572
Tel + 610 687.5644
Fax + 610.687.4236
www.milliman.com

ACTUARIAL MEMORANDUM

Highmark Blue Cross Blue Shield Delaware

Individual Rate Filing- January 1, 2019

I, [redacted], am a member of the American Academy of Actuaries and meet its qualification standards for preparing individual rate filings. As a consulting actuary, I was requested by Highmark, Inc. ("Highmark") to review its rate filing for the individual market on and off the Delaware Exchange. The confidential material presented in this filing was prepared for the specific purpose of submitting the rating formula for the DE Insurance Department and may not be appropriate for other purposes. This filing represents rates for individuals sold or renewed effective January 1, 2019. The rates are guaranteed until December 31, 2019.

To the best of my knowledge and judgment, the following are true with respect to this filing:

1. Rates are established in accordance with generally accepted actuarial principles and the applicable Actuarial Standards of Practice. They are not excessive, inadequate, or unfairly discriminatory. Rates are reasonable in relationship to the benefits provided. However, it is certain that actual experience will not conform exactly to the assumptions used in this analysis. To the extent that actual experience is different from the assumptions used in developing the rates, the actual results will also deviate from the projected amounts.

2. In compliance with all applicable Delaware and Federal Statutes and Regulations (45 CFR 156.80 and 147.102).

3. The rating factors and rating methodology are reasonable and consistent with Highmark's business plan at the time of the filing.

[redacted]
Fellow, Society of Actuaries
Member, American Academy of Actuaries
June 21, 2018